U. S. Senate Committee on Indian Affairs
U. S. Senate Committee on Health, Education, Labor, & Pensions
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430 Dirksen Senate Office Building
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Mr. Chairman.

My name is Ralph Forquera. I am the Executive Director for the Seattle Indian Health Board, a position I have held since January of 1990. I am also the Director for the Urban Indian Health Institute, a division of the Seattle Indian Health Board established in July of 2000 to conduct research and perform epidemiologic studies on the health of urban Indians. I am an enrolled member of the Juaneno Band of California Indians, a state-recognized Indian tribe from the San Juan Capistrano region of southern California.

The Seattle Indian Health Board is a community health center, established in 1970 as a free clinic in what was then a U. S. Public Health Service Hospital in central Seattle. We are currently under a contract and hold several grants from the Indian Health Service under Title V of the Indian Health Care Improvement Act. We are one of 34 such non-profit, Indian-controlled corporations that contract with the Indian Health Service under Title V.

Twenty of the 34 existing urban Indian health organizations offer direct health care. The remaining 14 programs provide health education, information and referral assistance, and other services designed to improve access to health care. In addition, urban Indian health organizations play an important cultural role in many cities by offering programs and services that are culturally-appropriate and socially acceptable to the wide array of Indian people living in cities. In my organization in Seattle, we serve Indian people from over 150 American Indian tribes and Alaska Native villages each year. The role of providing an identifiable and culturally acceptable place in American cities for Indian people is an often overlooked effect of these programs that in many ways has become an essential part of the healing process for Indian people who often feel abandoned and isolated in American cities.

According to the 2000 census, the majority of Indian people in the United States now live in American cities. Over 70% of Americans self-identifying as American Indian alone or of mixed race on the census were living in American cities.

The trend toward urbanization has been steady since the 1950s when it was the policy of this nation to relocate Indians into cities in an ill-fated attempt to assimilate Indians into the broader society. Up to 160,000 Indian people were directly affected by the relocation and termination policies. There remains a sizeable number of urban Indians who carry the emotional scars of this experience with them, in some cases greatly influencing their behaviors and ability to trust government institutions, including our programs.

Little is known about the overall health status of urban Indians across the nation. While

urban Indian health has been a part of the Indian Health Service for nearly 30 years, only recently have formal efforts to document the health of urban Indians been attempted.

The lack of available data has made it difficult to defend the need for help in addressing the growing health crisis among urban Indians. However, in March of 2004, the Urban Indian Health Institute released a first national report documenting severe health disparities among urban Indians. Using data from the National Center for Health Statistics and the 1990 and 2000 U. S. Census, data known to be woefully inadequate, the report still found significantly higher rates of illness and identified multiple known risk factors that likely contribute to these findings. The report brought greater attention to the plight of urban Indians and helped us to begin to build interest in looking at the health of this population. The report documented, for the first time, our anecdotal assertions that urban Indians were experiencing ill health in disproportionate numbers. A principle partner in this work today is the Indian Health Service which has now included us as one of the 10 Indian Health Service regional tribal epidemiology centers – ours being the only center with a national focus on urban Indians.

Title V provides the critical link in recognizing that Indian Country encompasses both reservation and urban communities. The 34 urban Indian health organizations reflect the nature of their local communities. They offer not only services, but a place of Indian identity that is frequently lacking for Indian people in American cities. In the broadest sense of healing, finding a place of belonging and acceptance can have a powerful positive effect on the health of Indian people.

Our ability to focus on Indian people and not be encumbered by the restrictive nature of limiting services to federally-recognized tribal members adds to our capacity to heal old wounds.

Title V is the only direct authority that specifically defines a health care role for the Indian Health Service in addressing the needs of urban Indians. For this reason, Title V is an essential tool in assuring that urban Indians are not forgotten as a group of Americans in need of health improvements.

In the request for my participation in this hearing today, two specific questions were posed for me to address. The first deals with the extension of Federal Tort Claim Act protection for urban Indian health organizations. The second is a concern that has periodically been brought up by the Department of Justice regarding the equal protection provisions of the Constitution and the fact that urban Indians are not subject to tribal governments with powers of self-governance.

With regard to the Federal Tort Claim Act Coverage issue, similar protections have been extended to community health centers through the Public Health Services Act. Those of us who receive funding through the Bureau of Primary Health Care are already eligible for FTCA protection. It would seem to me that extending this protection to urban Indian health programs would add minimal risk to the government given that many of the current urban programs do not offer direct health care at this time. Inclusion could save

considerable expense for those programs who are now purchasing private liability insurance to support their work. The resulting savings could be used to provide needed services.

It should also be noted that the Title V program was crafted using the community health centers as a model. The extension of a similar privilege for another group of federally-sponsored safety net providers seems a fair and equitable action.

With regard to the Department of Justice's concern about equal protection matters, I first need to state that I am not an attorney nor am I professionally trained in this area. However, it seems to me that the enactment of Title V defined a special class of health care provider similar to various special arrangements made through other federal programs like the Federally Qualified Health Center program in BPHC and disproportionate share hospital payment structure under CMS. Clearly the Federal government has a rational basis for providing funding, tax breaks, and other benefits it deems to be in the interest of the government or society in general and that rational basis should allow such distinctions to withstand an equal protection challenge. In the case of the urban Indian health programs, the Congress has a clear rational basis for its decision to provide programs, services and funding to urban Indians. After all, it was the ill conceived policies of relocaton and termination that led to the the removal of large numbers of Indian people from the reservations to the cities. Congress dealt with Indians as a special class of citizens then and it clearly can and should do so now as it tries to rationally address the consequences of those policies.

The structure of the Title V program, that of using a non-profit, Indian-controlled corporate structure, offers the full benefits of the self-determination principles called for in President Nixon's Special Message to the Congress in July of 1970 that forms the foundation of today's federal Indian policy. Successful urban Indian organizations, in some respects, embody the spirit of self-determination. Our use of IHS funds to leverage other public and private resources to extend our capacity to serve urban Indians is exactly what I believe the authors of Title V intended.

It seems clear that the Congress has the authority and the will to direct a program to address identified and documented health disparities affecting urban American Indians and Alaska Natives. In these times of a rapid change in the health care system in America and the sharp escalation in the cost of health care, the importance of having organizations devoted to assuring access and quality health care for Indian people makes good public policy. It is fitting that the Congress continue this policy by reauthorizing Title V.

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Permit us to continue our effort to raise the health of Indian people, both on and off reservation, to its highest possible level. Provide us with the authority, the guidance, and the financial resources needed to achieve this noble goal.

Thank you for offering me this opportunity to testify today. I will be happy to answer any questions.